Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 4, 2022
Inspection Number 2022_1515_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Wexford Residence Inc.

Long-Term Care Home and City
The Wexford, 1860 Lawrence Avenue East, Scarborough, ON, M1R5B1

Lead Inspector
April Chan (ID#704759)

Additional Inspector(s)
Joanne Zahur (ID#589)

Inspector Digital Signature
April W Chan
2022.05.06 12:24:07 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 21, 22, 25-29, 2022.

The following intake(s) were inspected:

- Intake # 020697-21 related to alleged abuse and infection prevention and control practices,
- Intake # 017390-21 related to restraint use.

The following follow-up intake was inspected:
- Intake # 019816-21 related to transfers

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Ins938758_003pection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	r. 36	2021_938758_0003	001	#589

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

- Resident Care and Support Services
- Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 272

The licensee failed to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter in the home.

Rationale and Summary
During observations on April 27, 2022, at staff member did not follow the home's process to be actively screened for symptoms and exposure to COVID 19 prior to entering the home.

The home notified the staff member and asked them to return to the entrance for active screening. The staff member did not interact with residents and returned to complete the screening questions and was permitted into the home.

Date Remedy Implemented: April 27, 2022 [s. 272] (704759)

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (7)

The licensee has failed to ensure that care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care (MLTC) related to an allegation of inappropriate use of a prescribed medication as a chemical restraint.

The resident exhibited responsive behaviours. A medication was recommended by an external specialist for the resident. The power of attorney (POA) for the resident consented, with instructions to notify them prior to administration of the medication.

The prescribed medication was given to the resident on three specific dates, without notifying the POA prior to administration. A nurse manager (NM) acknowledged that prior to administration of prescribed medication, the POA should have been notified as per the plan of care for the resident.

There was low risk of harm to the resident when staff members did not notify the POA prior to administering the medication.

Sources: Clinical record for the resident, plan of care, progress notes, medication administration records, Interviews with registered staff members and nurse manager. [s. 6. (7)] (704759)

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that additional precautions under the infection prevention and control program were followed by a visitor to the home.

Rationale and Summary
On April 25, 2022, inspector #704759 observed a visitor sitting with a resident inside their room with posted signs outside the entryway showing that the resident was under contact precautions. The visitor was not wearing gown or gloves as required personal protective equipment under the infection prevention and control program.

A staff member was informed about the visitor however the visitor was not approached about personal protective equipment to be worn.

Registered staff indicated that gown and gloves should have been worn by staff and visitors who entered the resident's room. Staff members were expected to provide instructions on additional precautions to visitors and report concerns to nursing staff on the unit as needed.

There was no identified risk of harm to the resident when the visitor did not follow contact precautions under the infection prevention control program.

Sources: observation in the home, interviews with direct care staff and registered staff members, and Director of Care (DOC). [s. 102. (2) (b)] (704759)

WRITTEN NOTIFICATION CMOH AND MOH

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 272

The licensee has failed to ensure that universal masking under Directive #3 issued by the Chief Medical Officer of Health was followed by a visitor to the home.

Rationale and Summary
On April 25, 2022, inspector #704759 observed a visitor sitting with a resident inside their room. The visitor was not wearing a medical mask.

A staff member was informed about the visitor however the visitor was not approached or instructed to don a medical mask for the duration of their visit. The visitor exited the room, passing through common areas of the home without a medical mask.

Interviews with registered staff indicated that all visitors and essential caregivers must wear a medical mask throughout their visit to the home. Staff members were expected to remind visitors about masking requirements and report concerns to nursing staff on the unit as needed.

There was risk of infectious disease transmission to the resident when the visitor was not wearing a medical mask while spending time in a room together. There was low risk to other residents in the common areas.

Sources: observation in the home, interviews with direct care staff and registered staff members, and DOC. [s. 272.] (704759).

WRITTEN NOTIFICATION PLAN OF CARE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (4) (b)

The licensee has failed to ensure that the registered staff and others involved in the different aspects of care of a resident collaborated with each other in relation to the discontinuation of isolation precautions.

Rational and Summary
A complaint was submitted to the MLTC that the long-term care home (LTCH) did not discontinue isolation precautions for a resident, resulting in an extra day of isolation.

The complainant indicated the LTCH had discontinued isolation precautions for the resident on a specific date, however when the complainant visited the next day, the isolation precautions signage and the yellow personal protective equipment (PPE) caddy remained on the resident's door. When the complainant asked about the discontinued isolation, the staff verbalized the isolation had not been discontinued.

A registered staff member acknowledged that the staff had not removed the isolation signage and yellow PPE door caddy on the specified date, which would have indicted to staff that the resident was no longer in isolation.

The DOC acknowledged that the isolation precautions for the resident had been discontinued on the specified date, as evidenced by a progress note entry, and that staff had not removed the signage nor the yellow PPE door caddy, resulting in the resident being in isolation for an extra day.

Sources: the resident's progress notes; interview with the complainant, interview with registered staff and Director of Care and other staff. [s. 6. (4) (b)] (589)

WRITTEN NOTIFICATION LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 23 (1) (a) (i)

The licensee failed to ensure an allegation of physical abuse related to a resident was immediately investigated.

Rationale and Summary:
A complaint was received by the MLTC in which the complainant noted skin alteration on a resident and alleged that a personal support worker (PSW) had been rough with the resident.

Interview with the DOC indicated that because of the allegations of abuse in relation to the resident, not being reported to the MLTC, there had not been any investigation conducted.

There was no harm to the resident.

Sources: complaints binder, interview with the complainant, interviews with nurse managers and Director of Care. [s. 23. (1) (a) (i)] (589)

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 24 (1) (2)

The licensee has failed to immediately report an incident of alleged and suspected abuse to a resident.

Summary and Rationale:
A complaint was received by the MLTC in which the complainant noted skin alteration on the resident and alleged that a PSW had been rough with the resident.

A nurse manager acknowledged that the complainant alleged abuse and that the skin alteration were related to a specific PSW working on the specified date. Both nurse managers acknowledged that this allegation of suspected abuse had not been reported to the MLTC.

There was minimal risk of harm to the resident when reporting requirements were not met.

Sources: resident's progress notes; interview with the complainant, interviews with nurse managers and Director of Care and other staff. [s. 24 (1) (2)] (589)